The Family Healing Spot, LLC

General Pain Index Questionnaire

Name _____ Date _____

We would like to know how much your pain **presently** prevents you for doing what you would normally do. Regarding each category, please indicate the **overall** impact your present pain has on your life, not just when the pain is at its worst.

*Please **circle the number** which best describes how your typical level of pain affects these six categories of activities.*

1. Family / At-home responsibilities such as yard work, chores around the house or driving the kids to school –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

2. Recreation including hobbies, sports or other leisure activities –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

3. Social activities including parties, theater, concerts, dining-out and attending other social functions –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

4. Employment inducing volunteer work and homemaking tasks –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

5. Self-Care such as taking a shower, driving or getting dressed –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

6. Life-Support activities such as eating and sleeping –

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

Score _____

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Health Assessment Questionnaire

Name _____ Date _____

Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
DRESSING & GROOMING				
Are you able to:				
Dress yourself, including shoelaces and buttons?	☐	☐	☐	☐
Shampoo your hair?	☐	☐	☐	☐
ARISING				
Are you able to:				
Stand up from a straight chair?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
EATING				
Are you able to:				
Cut your own meat?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Open a new milk carton?	☐	☐	☐	☐
WALKING				
Are you able to:				
Walk outdoors on flat ground?	☐	☐	☐	☐
Climb up five steps?	☐	☐	☐	☐

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

☐ Devices used for Dressing (button hook, zipper pull, etc.)

☐ Built up or special utensils

☐ Crutches

☐ Cane

☐ Wheelchair

☐ Special or built up chair

☐ Walker

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Dressing and grooming ☐ Arising ☐ Eating ☐ Walking

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Place an "X" in the box which best describes your abilities over the PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
HYGIENE				
Are you able to:				
Wash and dry your body?	☐	☐	☐	☐
Take a tub bath?	☐	☐	☐	☐
Get on and off the toilet?	☐	☐	☐	☐
REACH				
Are you able to:				
Reach and get down a 5 pound object (such as a bag of sugar) from above your head?	☐	☐	☐	☐
Bend down to pick up clothing from the floor?	☐	☐	☐	☐
GRIP				
Are you able to:				
Open car doors?	☐	☐	☐	☐
Open previously opened jars?	☐	☐	☐	☐
Turn faucets on and off?	☐	☐	☐	☐
ACTIVITIES				
Are you able to:				
Run errands and shop?	☐	☐	☐	☐
Get in and out of a car?	☐	☐	☐	☐
Do chores such as vacuuming or yard work?	☐	☐	☐	☐

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

☐ Raised toilet seat
☐ Bathtub bar
☐ Long-handled appliances for reach
☐ Bathtub seat
☐ Long-handled appliances in bathroom
☐ Jar opener (for jars previously opened)

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Hygiene
☐ Reach
☐ Gripping and opening things
☐ Errands and chores

Your ACTIVITIES: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

COMPLETELY	MOSTLY	MODERATELY	A LITTLE	NOT AT ALL
☐	☐	☐	☐	☐

Your PAIN: How much pain have you had IN THE PAST WEEK?
On a scale of 0 to 100 (where zero represents “no pain” and 100 represents “severe pain”), please record the number below.

Your HEALTH: Please rate how well you are doing on a scale of 0 to 100 (0 represents “very well” and 100 represents “very poor” health), please record the number below.
